Strengthening the Education Sector Response to School Health, Nutrition and HIV/AIDS in the Caribbean Region:

A Rapid Survey of 13 Countries

Antigua, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Anguilla (Joint British & Dutch Overseas Caribbean Territories), St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, and Trinidad & Tobago

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EDUCATION SECTOR HIV AND AIDS COORDINATOR NETWORK

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Edited by: Tara O'Connell, Mohini Venkatesh and Donald Bundy.

Coordinated by: EduCan, EDC, PCD, The World Bank and UNESCO

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List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CARICOM	Caribbean Community
EDC	Education Development Center
EduCan	Caribbean Education Sector HIV and AIDS Coordinator Network
EFA	Education for All
FRESH	Focusing Resources on Effective School Health
HFLE	Health and Family Life Education
FTI	Fast Track Initiative
HIV	Human Immunodeficiency Virus
IADB	Inter-American Development Bank
MoE	Ministry of Education
MoEs	Ministries of Education
MoH	Ministry of Health
MDGs	Millennium Development Goals
NCDs	Non-communicable Diseases
OVC	Orphans and vulnerable children
PCD	The Partnership for Child Development
SHN	School Health and Nutrition
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WB	The World Bank
WHO	World Health Organization

Executive Summary

Globally, the education sector has come to play an increasingly important role in the health and nutrition of the school-age child. This is largely in response to research conducted over the past two decades which has shown that poor health and malnutrition are critical underlying factors for low school enrolment, absenteeism, poor classroom performance and dropout; all of these outcomes act as important constraints in countries' efforts to achieve Education for All (EFA) and their education Millennium Development Goals (MDGs).

Caribbean governments have identified nutrition, infectious diseases including HIV, non-communicable diseases, and violence as priority areas to address in meeting the health and nutrition needs of school-age children in the region. They have also recognized that, as elsewhere in the world, some of the major causes of death in the adult population, including diabetes, hypertension and heart disease, have their roots in behaviour patterns established during childhood and youth. Furthermore, schoolchildren in the emerging middle income countries of the Caribbean face the dual burden of diseases of prosperity, including obesity and diabetes, alongside diseases of poverty and social deprivation, such as malnutrition. The Caribbean is also challenged as being, according to UNAIDS, the second most HIV-affected region of the world, with sub-Saharan Africa being the most affected.

In response to these challenges, education and health sector leadership in the Caribbean has committed to addressing the health and nutrition needs of school-age children through a broad school based health and nutrition (SHN) program that specifically includes HIV prevention and mitigation initiatives. At the Caribbean Community (CARICOM) Council on Human and Social Development (COHSOD) high-level meeting held in Port-of-Spain, Trinidad in June 2006, the Caribbean Ministers of Education and representatives of the National AIDS Authorities identified a need for education ministries to each appoint a focal person for school health activities, and for the creation of a regional mechanism for the sharing of school health information, with a focus on HIV. The resulting Caribbean Education Sector HIV and AIDS Coordinator Network (EduCan) was tasked with promoting the sharing of information and capacity building on national education sector responses to HIV throughout the Caribbean, with the overall goal of strengthening the role of the education sector in preventing HIV in the region.

The overall objectives of this rapid survey undertaken by EduCan in early 2008 are to inform the development of both regional and national level education sector policies and strategies on school health, nutrition and HIV in the Caribbean region. The survey also aims to describe the current situation of education sector response to school health, nutrition, HIV and stigma, and to provide a base-line for monitoring progress. It also aims to provide data on the allocation and mobilization of resources used in such education sector responses across the region.

Ministry of Education (MoE) HIV/AIDS coordinators[1] answered a questionnaire covering issues on health-related school policies; safe and supportive school environment; skills-based health education; school-based health and nutrition services; and support to MoE SHN and HIV responses. Of the 14 countries and territories represented in the EduCan Network, the 13 countries of Antigua, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Anguilla (Joint British and Dutch Overseas Caribbean Territories), St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago responded to the questionnaire.

Key findings of the survey are as follows:

Health-related school policies

- Nine of the 13 MoEs have policies, strategies and work plans in place, demonstrating their commitment to SHN and HIV response.
- Ten of the 13 MoEs have a national policy on free and universal primary education to reduce financial barriers of education for orphans and vulnerable children.
- Ten out of 13 countries have an existing management framework in place for MoEs to manage and mainstream their response to SHN and HIV. Such a framework may include a SHN/HIV unit within the MoE, seen in seven countries; an inter-departmental coordination committee on SHN/HIV, in seven countries; and a HIV/AIDS coordinator at national and sub-national level, in 10 and three countries respectively. The national HIV/AIDS coordinator is financed by the MoE in six countries, and by the Ministry of Health (MoH) in two countries.
- Twelve out of the 13 MoEs collect some data to facilitate ongoing monitoring and evaluation of their SHN programs. This data may include information on teacher training, school sanitation and teacher attrition.

Safe and supportive school environment

- All 13 countries have a mechanism in place to ensure that there is a safe and healthy environment in schools. This includes the presence of policies and practices to ensure that schools have safe water and sanitation, as found for eight and 10 countries respectively; are hygienic, reported by all countries; and promote the psychosocial well-being of teachers and students, as reported by 10 countries.
- Six of the 13 MoEs conduct annual sanitation surveys in all schools as a means of monitoring the implementation of safe school environment policies and improving and scaling up interventions.

[1] This includes MoE Health and Family Life Education (HFLE) coordinators, education officers and guidance counsellors who also serve as HIV/AIDS coordinators.

Skills-based health education

- In all 13 countries, to varying degrees, the education sector is involved in providing skills-based health education including HIV prevention to staff and students. Schools generally utilize both a curricular and a peer-education approach in order to deliver important life skills education. Under the curricular approach, health and HIV prevention education is generally taught as part of health and family life education (HFLE), which provides information on many different health concerns, such as hygiene, nutrition, and disease prevention. Ten countries also deliver HIV prevention education in the non-formal setting.

- In 12 of the 13 countries, teachers are trained in life skills education. Teacher training on life skills and HIV is provided more often in-service than pre-service. In all 13 countries teachers are trained to teach HIV prevention education.

School-based health and nutrition services

- All 13 countries, to varying degrees, are involved in providing health and nutrition services to school-age children and teachers. Vaccinations and hearing and sight examinations take place in all 13 countries; school feeding takes place in 12 countries; iron and vitamin A supplementation take place in four and two countries respectively. Deworming for school-age children takes place in eight countries. Reproductive health services are provided to youth in 11 countries; while in 12 countries counseling is provided to teachers and other education employees.

- Vaccinations and hearing and sight examinations is provided by MoH employees in all countries providing these services.

- Where school feeding is provided, it is administered by teachers, except for the Bahamas where it is provided by MoH employees. Deworming in six of the eight countries is administered by MoH employees.

Support to MoE SHN and HIV responses

- Ten of the 13 MoEs receive external support for education sector responses to SHN and HIV. This support is derived from various sources including the private sector, NGOs and UN agencies (including World Bank). Seven MoEs contract or partner with NGOs to assist in the implementation of HIV prevention education. Separately, eight MoEs work with the private sector for support to HIV prevention education. Guyana is the only country eligible for EFA Fast Track Initiative (FTI) funding; funds are used for SHN activities such as provision of water and sanitation in schools.

Conclusions and recommendations drawn from the survey are as follows:

Overall, the rapid survey found that Government leaders of the Caribbean are committed to reaching children and adolescents with information as well as training in life skills with the knowledge, attitudes, and values needed to make sound health-related decisions that promote lifelong healthy behaviours A majority of MoEs have established effective policies and strategies for addressing SHN, HIV and other infectious diseases. As such since common NCDs (e.g. obesity and type 2 diabetes) are emerging areas of concern in the region, greater policy emphasis on NCDs may prove beneficial.

At this stage, the focus might effectively shift from creating a policy environment to implementing strategies. Questionnaire responses reveal that in all countries the education sector response to school health, nutrition and HIV is underway and is being further developed and refined to more effectively address the health conditions specific to Caribbean school-age children.

The findings identify areas where a strong education sector school health and HIV response is already present, such as the provision of skills-based health education through HFLE and the school-based provision of vaccinations, as well as areas that might benefit from further strengthening, such as monitoring the impact of programs. School feeding is near universal in the 13 countries and territories while micro-nutrient supplementation is, however, very focal. Anecdotal experience suggests that there may be need for greater focus on the quality of food consumed by school-aged children. In the context of the region's growing epidemic of common NCDs, there is opportunity to consider the coverage of micro-nutrient supplementation and to assess the quality of food provided through school feeding programs and accessed through food vendors in schools.

There is clear evidence that schools have placed strong emphasis on ensuring a hygienic and safe environment with psychosocial support for students in school. This survey did not assess the availability of exercise facilities in schools but this may be an important factor for consideration given the emergence of common NCDs in Caribbean school-age children.

There is generally a high level of teacher training provided in the countries of the Caribbean. This typically includes training in life skills education and in relation to delivering HIV prevention messages. Teacher training, however, is primarily provided in-service and not as a substantive component in preparing teachers pre-service for teaching careers. This might indicate a need to focus on ensuring skilled teachers equipped with sexuality training.

Thus, by providing a comparative perspective across the region on both education sector responses to school health, nutrition and HIV, and on the allocation and mobilization of resources used in such responses, the rapid survey is intended to inform policy makers and to enhance the quality and outcomes of subsequent investments and future programs. It is anticipated that the findings of this rapid survey will be presented at the next CARICOM COHSOD meeting scheduled to be held in Jamaica in early June 2009 for consideration by the Ministers of Education and National AIDS Authorities, and will feed into discussions of the way forward.

Introduction 1

1.1 Health, nutrition and HIV of Caribbean school-age children

Recent studies point to a number of current and emerging concerns in the health and nutrition of school-age children in the Caribbean region. Critical among them are: infectious diseases including HIV and other sexually transmitted infections (STIs); non-communicable diseases (NCDs); and violence. Common health conditions including diabetes, hypertension and heart disease in the adult population can be positively linked to unhealthy lifestyles in youth.

These health challenges, combined with a large school-age population, which in some countries may be a sizable third of the overall population, make a strong national response to the health and nutritional needs of school-age children particularly vital. As lifelong patterns of behaviour and thinking are established during youth, it is critical to ensure early and widespread promotion of healthy practices related to sexual behaviour, nutrition and a healthy lifestyle in general in the school-age population, resulting in a healthier adult population in the future.

1.2 Education Sector Role in Health, Nutrition and HIV

Recognizing that the health of an adult population has direct links to lifestyle and behavioural choices cultivated in childhood, the education sector in low-income countries has come to play an increasingly important role in the health and nutrition of the school-aged child. Evidence suggests that school-based health and nutrition (SHN) programs delivered through the education sector have a dual role to play: first, in affecting positive behaviour change for a healthier lifestyle and, second, in promoting better learning outcomes. This is supported by research over the past two decades which has shown that poor health and malnutrition are critical underlying factors for low school enrolment, absenteeism, poor classroom performance and dropout; all of which act as important constraints in countries' efforts to achieve Education for All (EFA) and their education Millennium Development Goals (MDGs).

Thus, programs have focused on improving health and nutrition for all children, particularly for the poor and disadvantaged, in order to reap education and subsequent economic gains. In the 1990s, when EFA was launched, SHN programs became increasingly incorporated in education sector responses to ill health among school-age children, as part of EFA programs. A major step forward in international coordination was achieved at the World Education Forum in Dakar in April 2000, where a joint partnership effort by UNESCO, UNICEF, WHO and the World Bank led to Focusing Resources on Effective School Health (FRESH). Based on good practice recognized by all the partners, the FRESH framework suggests a core group of cost effective activities which can form the basis for effective implementation of comprehensive SHN programs. FRESH's consensus approach has increased significantly the number of countries implementing school health reforms.

The four core components of an effective school health program, as suggested by FRESH are as follows:

1. Health-related school policies: including those that address HIV issues, and gender.

2. Safe and supportive school environment: including access to safe water, adequate sanitation and a healthy psychosocial environment.

3. Skills-based health education: including curriculum development, life skills training, teaching and learning materials.

4. School-based health and nutrition services: including deworming, micronutrient supplementation, school feeding, dengue prevention and psychosocial counseling.

These components can be implemented effectively only if supported by strategic partnerships between: the health and education sectors (especially teachers and health workers), schools and communities, and pupils and stakeholders (Jukes *et al*., 2008).

1.3 Non-Communicable Diseases

There is increasing recognition of the importance of NCDs for school-age children, and the importance of school health programs in promoting the healthy life styles that help avoid NCDs in later years. This is true for all countries, but is particularly apparent in countries that are developing economically. With economic growth there are often improvements in sanitation and health services and concomitant reductions in infectious diseases, giving greater relative importance to NCDs. At the same time, growth is often associated with dietary changes and increasingly sedentary life-styles that can drive an epidemic of obesity and type two diabetes in school children, and lead to increased rates of cardiovascular and other non-communicable diseases in adulthood. To address these issues, SHN programs seek to promote life-long healthy habits by providing effective life-skills programs, by enhancing the quality of the diet available at school, especially that provided by school feeding programs, and by providing school children with the time and facilities to encourage regular exercise.

1.4 HIV and Education

There has been a strong focus on HIV both globally and in the Caribbean region within the context of education. in recent years, the education sector has played an increasingly important role in preventing HIV as key events around the millennium leading up to the Dakar World Education Forum, such as the advocacy by Michael Kelly of Zambia at the 1999 Lusaka International Congress on HIV/AIDS and STIs in Africa, have given new impetus to the HIV response of the education sector.

School-age children have the lowest HIV infection rates of any population sector. Globally and throughout the Caribbean, even in the worst affected countries, the vast majority of schoolchildren are not infected. For these children, there is a 'window of hope', a chance to live a life free from AIDS, if they can acquire knowledge, skills, and values that will help to protect them as they grow up.

Education contributes to the attainment of knowledge, skills and values essential for the prevention of HIV. It protects individuals, families, communities, institutions and nations from the impact of HIV. Young people, and particularly girls, who fail to complete a basic education, are more than twice as likely to become infected, and some seven million cases of AIDS could be avoided by the achievement of EFA (GCE, 2004). Providing young people with the 'social vaccine' of education offers them a real chance at a productive life.

Education has also been shown to increase understanding and tolerance, dramatically reducing levels of stigma and discrimination against vulnerable and marginalized communities and people living with HIV (CARICOM *et al.* UNESCO, 2007; World Bank, 2002). Additionally, education has an important role to play in providing access to care, treatment, and support for teachers and staff – a group that represents a significant portion of the public sector workforce in many countries.

It is, however, important to ensure that adolescents and young people are accessing education with appropriate and actionable HIV prevention messages. Simply supplying facts about sex and HIV is not enough to alter risky behaviour. Information must be supplemented with training in life skills, such as critical and creative thinking, decision-making and self-awareness, and with the knowledge, attitudes, and values needed to make sound health-related decisions that promote lifelong healthy behaviours. To this end, governments have made efforts to strengthen the education sector response to HIV throughout the Caribbean region.

1.5 The Education Sector Response to HIV in the Caribbean

The Caribbean is the second most-affected region in the world with respect to HIV, after sub-Saharan Africa, with an HIV prevalence of 1.6%. Data indicate that figures for the prevalence of HIV for the less than 15 years population measure 7% of total infections, and other STIs, early pregnancy and multiple partners are on the rise among Caribbean youth. While prevalence in the Caribbean remains relatively low, evidence suggests that youth may be engaging in risky behaviour, and that stigma and discrimination are quite high (PAHO *et al.* 2006). The Caribbean Community (CARICOM) recognizes the education sector as a key partner within the multi-sectoral response to HIV.

For two decades, similar to patterns of response globally, the Caribbean response to the HIV/AIDS epidemic was largely focused within the health sector. Initial activities by the education sector to respond to HIV were concentrated on the provision of HIV education, and strengthening guidance and counseling within schools (Kelly & Bain, 2003):

- The Health and Family Life Education (HFLE) initiative in the early 1990s was a CARICOM multi-agency activity in response not only to HIV but more broadly to health and social problems such as pregnancy, violence, substance abuse, and nutrition among adolescents (Kelly & Bain, 2004). The program was first introduced in secondary schools, but was later extended to primary schools. In 1996 Education Ministers requested all CARICOM states to develop national HFLE policies and prepare plans to translate that policy into action.

- Guidance and counseling units have worked to promote safe behaviour through HFLE, build the capacity of teachers and guidance counsellors, support awareness raising activities, and develop community networks of parents, communities and the public.

- The Caribbean Network for health promoting schools was established in 1998. Issues relating to HIV were part of this broader health initiative.

- In addition to the above, some HIV-specific education initiatives were also implemented at national level on a country-to-country basis.

In November 2002, recognizing the potential of HIV to deplete human resources throughout the Caribbean, Ministers of Education in a regional meeting in Havana committed to a more comprehensive response to the epidemic. This included prevention education, care and support of educators and learners, and measures to reduce the impact of the epidemic on education; all of these bring greater attention to the need for a systematic education sector response to the epidemic.

An assessment of the Caribbean education sector conducted in 2006 found that countries were at different stages in developing a comprehensive response to HIV (Whitman & Oommen, 2006):

- Only two countries had put in place an HIV or school health policy. Other countries were in the process of drafting such policy.

- All 12 countries assessed were implementing HFLE, but had variable concerns such as teacher training and timetabling of the curriculum.

- Eight of the 12 countries assessed reported having a policy for a safe and healthy school environment. However, they reported that discrimination against people living with HIV was a severe issue despite some efforts to sensitize the MoE staff.

- The provision of services, care and support was limited. Most Ministries did not provide any information about voluntary counseling and testing. HIV coordinators reported the need for more knowledge and skills in this area.

During a high level meeting of Ministers of Education and National AIDS Authorities, under the auspices of the Caribbean Community (CARICOM) Council on Human and Social Development (COHSOD) held in Trinidad & Tobago in June 2006, the Governments of CARICOM and the Dominican Republic developed and endorsed two documents identifying HIV as a key issue to be addressed within the education sector[2]. The documents were later presented to the July 2007 CARICOM meeting of heads of governments:

1. The Port-of-Spain Declaration, which signified the commitment of CARICOM Ministers of Education and other participants at the COHSOD meeting to review efforts to accelerate the education sector response to HIV in the Caribbean.

[2]This identification exercise involved a broad base of stakeholders including a number of UN agencies including the World Bank (WB), international development partners and civil society organizations.

2. The Port-of-Spain Action Framework, which codified an emerging consensus among participants in the COHSOD meeting around a core set of areas, listed below, to strengthen national HIV responses by the education sector (see Annex 6.1).
    a. Policy
    b. Planning and Management
    c. Prevention
    d. Orphans and Vulnerable Children

Through these documents, CARICOM made clear the intent to strengthen the multi-sectoral response to HIV in the Caribbean region. At the centre of the CARICOM plan for action is the development of a regional strategy as well as national strategic plans that emphasize quality EFA and lifelong learning experiences as central to the education sector response to the epidemic.

Later, in an effort to strengthen and harmonize education sector responses to HIV across the region, the Caribbean Ministers of Education and National AIDS Authorities during the June 2006 COHSOD meeting endorsed the establishment of the Education Sector HIV and AIDS coordinator Network (EduCan)[3]. The establishment of EduCan was facilitated by the Education Development Center (EDC), supported by the Inter-American Development Bank (IADB) and with UNESCO and the World Bank. The EduCan Network is tasked with promoting the sharing of information and capacity building on national education sector responses to HIV throughout the Caribbean. The overall goal of this Network is to strengthen the role of the education sector in preventing HIV in the region. The Network was established at the specific request of CARICOM and was formally presented to the Caribbean Ministers of Education and National AIDS Authorities at the CARICOM COHSOD meeting.

In March 2008, the EduCan Network organized a five-day annual-general meeting and capacity building workshop, bringing together HIV/AIDS coordinators from 13 of the 14 Ministries of Education it represents. This meeting focused on capacity building, including monitoring and evaluation (M&E) skills, and was part of a larger effort to understand the education sector responses of HIV in the Caribbean region.

To develop a cross-sectional overview of education sector HIV responses at both national and regional level, a questionnaire survey was conducted prior to the meeting. As HIV prevention education is integral to comprehensive SHN programming, the rapid survey also collected information on the overall SHN response in Network countries. The responses from countries were discussed at the meeting. This report presents the findings of this rapid survey and is intended for presentation to the Ministers at the CARICOM COHSOD Meeting scheduled for early June 2009.

[3]Article 17 of the Declaration. The 14 countries and territories with representation in the EduCan Network are: Antigua, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, Joint British and Dutch Overseas Caribbean Territories, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

Objectives and Methodology 2

2.1 Objectives

This rapid survey has been conducted to inform the development of both regional and national level education sector policies and strategies on school health, nutrition and HIV in the Caribbean region. It aims to provide policy makers and practitioners with a comparative perspective of education sector activities and initiatives implemented across the region to address school health, nutrition, HIV and stigma. It also aims to provide data on allocation and mobilization of resources used in the response to school health, nutrition and HIV across the region.

The specific objectives of the survey are to:

- Allow the education sector in participating countries to monitor their progress against the core set of actions to strengthen national SHN and HIV responses by the education sector, as outlined in the Port-of Spain Action Framework and FRESH.
- Identify priority areas in SHN and HIV in each country, enabling government officials to concentrate resources and programming in these areas.
- Identify good practice in SHN and HIV specific to the Caribbean context.
- Aid in future planning both within each country and collectively across the region.

2.2 Methodology

Ministries of Education in the 14 EduCan countries (see Table 1) were contacted for the survey and were asked that their HIV/AIDS coordinators[4] complete a questionnaire about national responses to SHN and HIV[5] (see Annex 6.2). A 93% response rate to the questionnaires was achieved. No response was received from Suriname and the HIV/AIDS focal point for Suriname was not able to attend the March 2008 EduCan meeting. One-on-one discussion with each HIV/AIDS coordinator attending the EduCan meeting followed submission of responses, and was used to clarify responses as needed.

The questionnaire was guided by the *FRESH* framework on SHN and the *Port-of-Spain Frameworks* on HIV. Responses related to similar issues in both frameworks (e.g. *health-related school policies in FRESH* and the *Sector Policy* in the *Port-of Spain Framework*), were analyzed under the more generic FRESH component. Responses which covered aspects of the *Port-of Spain Frameworks* while complementing a *FRESH* component (e.g. information on *Prevention overlapped with Skills-based health education*) were also analyzed under the broader FRESH component. The key areas thus analyzed during the rapid survey fell under the four main components of FRESH, as follows:

- Health-related school policies (which included issues on planning and management, and orphans and vulnerable children)
- Safe and supportive school environment
- Skills-based health education (which included questions on curriculum and teacher training)
- School-based health and nutrition services

Information on resources available in countries to support SHN and HIV responses was an additional area of assessment.

The information in this survey mostly pertains to primary and secondary education. Information on HIV prevention activities in the non-formal education sector is also included because the sector provides a means of reaching out-of-school youth who might be more vulnerable to HIV.

Table 1. List of EduCan Network countries

Antigua
The Bahamas
Barbados
Belize
Dominica
Grenada
Guyana
Jamaica
Joint British and Dutch Overseas Caribbean Territories
St. Kitts and Nevis
St. Lucia
St. Vincent and the Grenadines
Suriname
Trinidad and Tobago

There are some important considerations regarding the analyses and interpretation of the survey data. First, percentages are calculated for countries that reported a response activity out of the total 13 countries that responded to the survey. Percentages have not been statistically analyzed because of the small denominator in the Network. Second, the interpretation of results sometimes proved difficult because either there were no responses to questions, or follow up information about the program was not available. There is also a margin of error to consider in the completion of the questionnaire. Last, the fact that the data collected were in relation to national SHN and HIV responses precludes their use to indicate program coverage and success at sub-national level. As information on the extent of activities at country level is also not captured as part of this survey, it needs further investigation.

[4] This includes MoE Health and Family Life Education (HFLE) coordinators, education officers and guidance counsellors who also serve as HIV/AIDS coordinators.

[5] Anguilla responded on behalf of the Joint British and Dutch Overseas Caribbean Territories (OCTs). Henceforth, responses will be referred to as Anguilla so as not to generalize national data with data for the collective OCTs.

Results and Discussion 3

3.1 Health-related school policies

Policies for SHN and HIV interventions are important because they demonstrate leadership commitment, and provide a framework to ensure that the health and education needs of children are holistically and systematically met in all schools. Table 2 displays policies and strategies relevant to education sector activities on health, nutrition and HIV that exist in the 13 EduCan countries that responded to the survey.

Table 2. Policies and strategies for SHN and HIV

Policy and Strategies	Anguilla	Antigua	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Jamaica	St. Kitts & Nevis	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
Education Policy within MoE	✗	✗	✓	✓	✓	✗	NR	✓	✓	✗	✗	✓	✓
Education Strategy within MoE	✗	✗	✗	✓	✓	✗	✓	✓	✓	✗	NR	✓	✗
National SHN Policy	✗	✗	✗	✓	✗	✗	✗	✓	NR	✓	✗	✗	✓
National SHN Policy implemented by MoH	NA	NA	NA	✓	NA	NA	NA	✓	NR	✓	NA	NA	✓
National SHN Policy implemented by MoE	NA	NA	NA	✓	NA	NA	NA	✓	NR	✗	NA	NA	✗
National HIV Strategy	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Education Sector HIV Strategy	✗	✗	✗	✓	✗	✗	✓	✓	✓	✓	✗	✗	✓
Education Sector HIV Action Plan	✗	✗	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓
National Workplace Policy	✗	✗	✗	✓	✓	✗	✓	✓	✓	✓	✗	NR	✓
HIV issues addressed in National Workplace Policy	NA	NA	NA	NR	✓	NA	✓	✓	✓	✓	NA	NR	✓
Education Sector HIV Policy that includes Workplace Regulations	✗	NR	✓	✓	NA	✗	NA	NA	NA	✓	NR	✓	✓

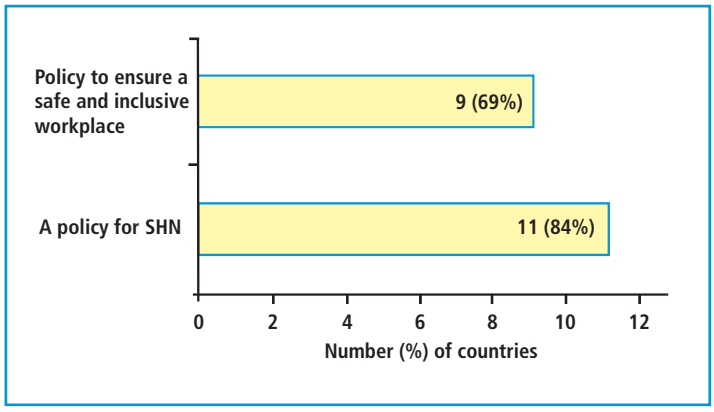
✓= yes, ✗= no, NA= not applicable, NR= no response to the question

Seven (54%) countries have a national education policy, while six (46%) have a national education strategy (see Table 2).

Four (31%) countries have a national policy on SHN, which is either published or in draft form. In St. Kitts and Nevis and Trinidad and Tobago the SHN policy is implemented by the Ministry of Health. In Barbados and Guyana the SHN policy is implemented jointly by both the Ministries of Education and Health. Belize has a Family Life and Health Education (HFLE) policy and is implemented by the Ministry of Education. Six additional countries without a specific national SHN policy reported that their national education policy advocates for child-friendly schools (see Section 3.3). St. Lucia is the only country without either policy, while information for Jamaica was not available. Therefore the total number of countries with policy arrangements for SHN is 11 (84%) (see Figure 1). Trinidad and Tobago also have a draft nutrition policy which is implemented by the MoE.

On HIV prevention and mitigation, although 12 countries (excluding Anguilla) have a national HIV strategy, only six (46%) countries reported having an education sector HIV strategy (see Table 2), which has also been incorporated in to action plans for implementation. In Trinidad and Tobago, the strategy recently expired. The Bahamas, St. Lucia, and St. Vincent and the Grenadines have education sector HIV action plans, but do not have long-term strategies in place. As the 'internal' role of the education sector in mitigating the impact of HIV on its staff becomes ever more recognized, workplace policies are seen as essential to ensure a safe and inclusive work environment. Seven (54%) countries reported having a national workplace policy. Six of these countries reported that this policy, which is applicable to the education sector, addresses HIV-related concerns. In three countries reportedly lacking national workplace policies, the Bahamas, Barbados and St. Vincent and the Grenadines, HIV/AIDS coordinators report the existence of workplace regulations within education sector HIV policies. Therefore the total number of MoEs with workplace arrangements that ensure an inclusive environment for those affected by HIV is nine (69%) (see Figure 1).

Figure 1: Number of countries with SHN and safe workplace policies



3.1.1 Orphans and Vulnerable Children

An essential HIV mitigation strategy is the removal of financial barriers that may prevent orphans and vulnerable children, particularly girls, from accessing education. The commitment of all states to offer free compulsory primary education, reaffirmed at the 2000 Dakar Forum, contributes to achieving this. Among the 13 Network countries, 10 (77%) reported the presence of a national policy to promote free primary Education for All (see Table 3). In another 10 (77%) countries, orphans and vulnerable children do not have to pay school tuition fees.

Table 3. Support for orphans and vulnerable children

Orphans and Vulnerable Children	Anguilla	Antigua	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Jamaica	St. Kitts & Nevis	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
National policy of free primary school EFA	✓	✓	✓	✓	✓	✗	NR	✓	NR	✓	✓	✓	✓
OVCs do not pay school tuition/fees	✓	✓	NR	✓	✓	✗	✓	✓	✗	✓	✓	✓	✓
Program for conditional cash transfers	✗	✗	✗	NR	NR	NR	NR	✗	✗	✗	✗	✗	✗
Affirmative action to boost enrolment/attendance of girls	✗	✗	✗	✓	✗	NR	NR	✗	✗	✓	✗	✗	✗
MoE keep data on OVC	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✓	✓	✗

✓= yes, ✗= no, NR= no response to the question

But ensuring that orphans and vulnerable children are able to attend school is only the beginning; they also require support to remain in school. Cash transfers conditional upon attendance have been shown an effective method in other regions. None of the countries reported to have programs of conditional cash transfers for orphans and vulnerable children.

Encouraging girls to attend school is essential for gender equity and for addressing the increasing feminisation of the HIV/AIDS epidemic in the Caribbean context. Young girls have been found more likely to be infected with HIV than boys in some countries in the Caribbean, making them more vulnerable to dropping out of school (UNAIDS, 2004). Only two (15%) countries, Barbados and St. Kitts and Nevis, reported having programs targeted to boost girls' enrolment and attendance. It is important to note, however, that there is relative parity between boys and girls access to primary education in the Caribbean. When transitioning to the secondary level, though, there is some attrition in the number of boys, resulting in a reverse gender gap and making a strong emphasis on girls' education less urgent in the Caribbean region.

Data on the number of orphans and vulnerable children is important for identification of children needing support and for estimating whether affirmative action programs have the desired impact on reducing inequities and achieving Education for All. Three (23%) countries collect data held by the MoE on orphans and vulnerable children and their participation in schools. Data on orphans and vulnerable children in some countries, such as Belize, is indeed collected nationally, but it is held by another ministry.

3.1.2 Planning and Management

In most countries, a management framework exists for MoEs to manage and mainstream their response to SHN and HIV. Seven out of 13 countries have an SHN and/or an HIV unit in their MoE. An SHN unit exists in five (39%) national MoEs and there is a full-time coordinator in four of these units (see Table 4). In Trinidad and Tobago, the SHN unit in the MoE primarily focuses on school nutrition; a separate unit for school health is present in the MoH. In Barbados, Guyana, and Trinidad and Tobago the SHN units are free-standing and not part of a directorate. Six (46%) countries either have an HIV section within their SHN unit or a separate HIV unit within the MoE. In the case of Belize, an HFLE unit in the MoE addresses SHN-and HIV-related activities.

All six countries with an established HIV section in the MoE have a designated national HIV/AIDS focal point or coordinator. Four additional countries, Grenada, St. Kitts and Nevis, St. Lucia, and Trinidad and Tobago, lack an HIV section in the MoE but have a designated HIV/AIDS coordinator. The HIV/AIDS coordinator in Trinidad and Tobago is attached to the Student Support Services Division. Thus, 10 (77%) of the MoEs have a HIV/AIDS coordinator. In Belize, HIV initiatives are part of the responsibility of an HLFE coordinator. The HFLE coordinator is a full-time staff member, with an official job-description. In eight out of the 10 MoEs with a HIV/AIDS coordinator, these are full-time positions (see Table 4). Six of these eight MoEs with full-time HIV/AIDS coordinators have an official job description for the position. In six countries, namely

Anguilla, Antigua, Grenada, Jamaica, St. Kitts & Nevis, and Trinidad & Tobago, the MoE finances the HIV/AIDS coordinator. In Guyana and St. Lucia the HIV/AIDS coordinator is financed by the MoH. Information on Bahamas and Barbados is not available. Details on the sources of funding for financing the coordinator were not collected.

At sub-national level, education sector coordinators for SHN and/or HIV/AIDS are present in only three countries, namely Barbados, Jamaica and Trinidad and Tobago. In Belize, the HFLE coordinators at district level are responsible for SHN-and HIV-related activities.

SHN and HIV inter-departmental committees in MoEs are important mechanisms to facilitate joint coordination and involvement of all education sub-sectors in the planning, management and mainstreaming of programs. Seven (54%) countries have an SHN and/or HIV inter-departmental committee within their MoE. In Belize the HFLE steering committee is responsible for responses relating to HIV.

Monitoring of programs and measuring of SHN and HIV related outcomes is fundamental to good planning and management and helps support the scale-up of activities. Seven (54%) countries reported collecting outcome data on health-related teacher attrition and absenteeism at least once per year.

3.2 Safe and supportive school environment

A safe and supportive school environment is essential for promoting the health, dignity and well-being of children and staff, and thus effective learning. Ten (77%) MoEs have national policies or regulations that ensure a safe and child-friendly environment in schools. St. Lucia reported no such policy. Information on Jamaica and St. Kitts and Nevis was not available.

In relation to the promotion of a safe environment, many MoEs have policies or regulations that require schools to provide safe water and sanitation facilities for their students and staff, and ensure a clean environment (see Table 5). In eight (62%) countries, schools are required to provide potable drinking water and hand-washing facilities. Similarly, gender-segregated latrines in schools are mandated in 10 (77%) countries. These same 10 countries also mandate separate latrines for students and teachers. All 13 (100%) countries have established school hygiene and cleaning regimens that include scheduled rubbish removal. All countries also reported that these regimens include maintenance of school buildings and facilities in all schools.

Table 4. Education sector planning and management for SHN and HIV

Planning and Management	Anguilla	Antigua	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Jamaica	St. Kitts & Nevis	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
SHN Unit in the MoE	✓	✗	✗	✓	✗	✗	✗	✓	✓	✗	✗	✓	✓
Full-time SHN Unit Coordinator	✓	NA	NA	✓	NA	NA	NA	✗	✓	NA	NA	NA	✗
Free-standing SHN Unit	✗	NA	NA	✓	NA	NA	NA	✓	NR	NA	NA	NA	✓
HIV part of the SHN Unit	✓	✗	✗	✓	NA	✗	✗	✓	✗	✗	✗	✗	✗
Separate HIV Unit in the MoE	NA	✓	✓	NA	✗	✗	✗	NA	✓	✗	NR	✗	✗
HIV/AIDS Coordinator in the MoE	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	✓	✗	✓
Full-time HIV/AIDS Coordinator	✗	✓	✓	✓	NA	NA	✓	✓	✓	✗	✓	NA	✓
Official Job Description for HIV/AIDS Coordinator	✗	✗	✗	✓	NA	NA	✓	✓	✓	✗	✓	NA	✓
SHN and/ or HIV/AIDS Coordinators at Sub-national Level	✗	✗	✗	✓	NA	✗	✗	✗	✓	✗	✗	NR	✓
SHN and/or HIV/AIDS Interdepartmental Committee within the MoE	✗	✗	✓	✓	NA	✗	✓	✓	✓	✓	✗	✗	✓
MoE collects data at least annually on health related attrition and absences of teachers	✗	✗	✗	✓	✓	✓	✓	✓	NR	✓	✗	✗	✓

✓= yes, ✗= no, NA= not applicable, NR= no response to the question

Table 5. National policies for safe and sanitary school environment

School Environment	Anguilla	Antigua	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Jamaica	St. Kitts & Nevis	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
National policies that promote a safe, child-friendly school environment	✓	✓	✓	✓	✓	✓	✓	✓	NR	NR	✗	✓	✓
National policies that require schools to provide safe, potable drinking water	✓	✓	✓	✓	✓	✓	✗	✓	NR	NR	✗	✗	✓
National policies that require schools to provide hand-washing facilities	✓	✓	✓	✓	✓	✓	✗	✓	NR	NR	✗	✗	✓
National policies that require schools to provide separate latrines for boys and girls	✓	✓	✓	✓	✓	✓	✓	✓	NR	NR	✓	✗	✓
National policies that require schools to provide separate latrines for students and teachers	✓	✓	✓	✓	✓	✓	✓	✓	NR	NR	✓	✗	✓
Established school hygiene regimen including scheduled rubbish removal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Established school hygiene regimen including maintenance of school buildings and facilities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Annual sanitation surveys conducted in all schools	✓	✗	✓	✓	✓	✗	✓	✗	NR	✗	✗	✓	✗
National policies that require schools to provide psychosocial support for students	✓	✓	✓	✓	✓	✓	✓	✓	NR	✗	✗	✓	✓

✓= yes, ✗= no, NA= not applicable, NR= no response to the question

Monitoring the implementation of safe school environment policies is important for improving and scaling up interventions. Existing tools for routine data collection provide an avenue for incorporating school sanitation and other SHN information to aid monitoring in this area. This allows SHN information to be available frequently without greatly adding to resources required to collect data. The coverage of annual sanitation surveys in schools is low, with six (46%) countries reporting completion of surveys in all schools (see Table 5).

Provision of psychosocial support to students is an important aspect of ensuring a healthy and secure school environment. Ten (77%) countries reported having policy regulations that ensure schools provide psychosocial support to students. Details of psychosocial support provided were not available.

3.3 Skills-based health education

Experience suggests that SHN and HIV prevention activities are most effective when presented as part of skills-based health education, which is provided using a curricular and/or peer education approach.

3.3.1 Curricular Approach

To ensure health messages delivered through schools are both consistent and relevant, a national health curriculum that is adaptable at local level is important. Twelve (92%) countries have a national health education curriculum (see Table 6). Ten (77%) of these countries also reported that the curriculum can be locally adapted for teaching at sub-national level. In St. Lucia, aspects of health are taught in some form at primary and secondary levels, but there is no national curriculum to support widespread inclusion.

All 13 responding countries reported that health education is taught as part of a separate subject generally called health and family life education. In Guyana, health education is infused in carrier subjects such as science and social studies from grade three onwards. Hygiene education takes place in primary and secondary schools in all countries; however data on the extent of activities within countries was not collected. Nutrition education also takes place in all 13 countries, in primary and/or secondary schools. Dengue prevention education was reported to take place in ten (77%) countries.

All 13 responding countries reported having HIV prevention education in schools, which is infused in a carrier subject (e.g. health and family life education). Ten (77%) countries indicated that HIV prevention education takes place in primary as well as secondary schools. Twelve (92%) countries reported using a life-skills approach for HIV prevention education in primary and secondary schools.

3.3.2 Peer Education Approach

Peer education, such as on HIV, involves students undertaking sensitization activities among their friends and classmates to increase their knowledge and motivate them to adopt healthy behaviours. Eleven (85%) countries reported adopting peer education within the education sector. All of these eleven countries reported that peer education takes place in secondary schools; while three (23%), namely Guyana, St. Kitts and Nevis, and St. Lucia, mentioned that it also takes place in primary schools.

Table 6. Presence of Skills-Based Health Education including HIV Prevention

Skills-Based Health Education	Anguilla	Antigua	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Jamaica	St. Kitts & Nevis	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
National health education curriculum	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
National health education curriculum which is adaptable at sub-national level	✓	NR	✓	✓	✓	✓	✓	✓	NR	✓	NA	✓	✓
Health education taught as separate subject	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutrition education in primary schools	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutrition education in secondary schools	✓	✓	✓	✓	✓	✓	✓	✓	NR	✓	✓	✓	✓
Hygiene education in primary and secondary schools	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dengue prevention education in schools	✗	✓	✓	✓	✓	✗	✓	✓	NR	✓	✓	✓	✓
Peer education within the education sector	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Peer education in primary schools	NA	NA	✗	NR	✗	NR	✗	✓	NR	✓	✓	✗	✗
Peer education in secondary schools	NA	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HIV prevention education in schools in any form	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HIV prevention education in primary and secondary schools	✓	✓	✓	✓	NR	NR	NR	✓	✓	✓	✓	✓	✓
HIV prevention education in the non-formal setting	✓	✗	✓	✓	✓	NR	NR	✓	✓	✓	✓	✓	✓
HIV education infused in a carrier subject	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HIV taught using a life skills approach in primary and secondary schools	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓
HIV taught using a life skills approach in the non-formal setting	✗	✗	✗	✓	✓	NR	NR	✗	✓	✓	✗	NR	✓

✓= yes, ✗= no, NA= not applicable, NR= no response to the question

3.3.3 HIV Prevention in the non-formal setting

The non-formal education sector has an important role to play in HIV prevention education to out-of-school youth who may be more vulnerable to infection. Ten (69%) countries reported the delivery of HIV prevention education in the non-formal setting. Five of the 10 countries reported using a life skills approach for the HIV prevention education in the non-formal sector (see Table 6).

3.3.4 Teacher Training

Teachers are uniquely placed – due to their contact hours with students and social status within society – to affect the knowledge, attitudes and behaviour of school-age children. Quality teacher training is a critical component in preparing and supporting educators and education personnel to address issues relating to SHN and HIV, and in implementing and sustaining an effective school health program. Without this training, teachers may be unable and unwilling to teach sensitive content in lessons (e.g. messages on HIV).

Questionnaire responses indicate that, in 12 (92%) countries, teachers are trained on life skills education (see Table 7). This training, however, is primarily delivered in-service as opposed to pre-service (see Figure 2). Training of teachers to teach issues on HIV reportedly takes place in all 13 countries. As with training related to life skills, training in HIV is more likely to be delivered in-service, as reported in 12 (92%) countries, rather than pre-service, as reported in seven (54%) countries (see Figure 2). All 13 responding countries provide training to teachers on how to protect themselves from HIV infection.

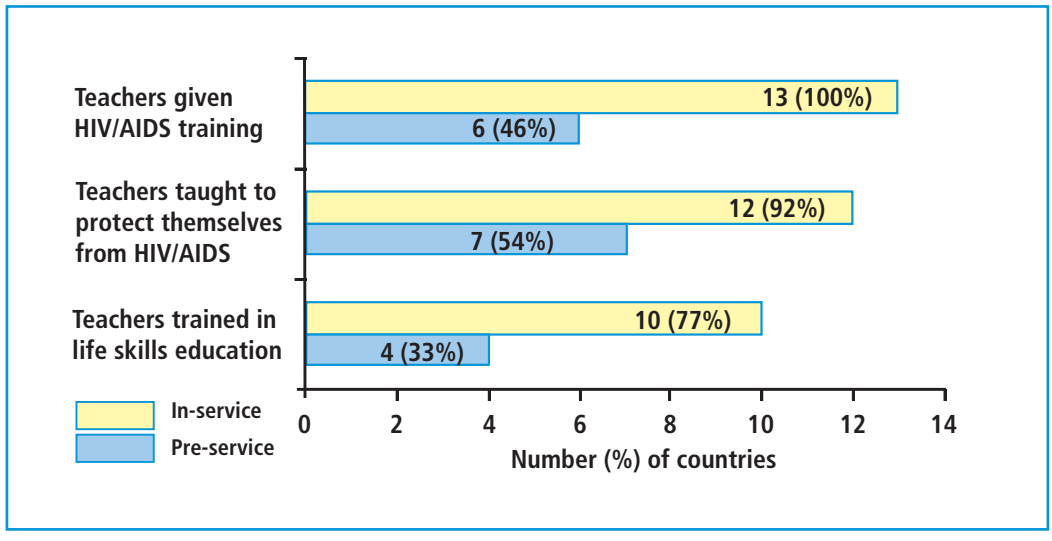
To support training of teachers for primary and secondary schools, 11 (85%) MoEs reported having teacher training materials. Data collection on both teacher training and training materials distributed is important for program monitoring and planning. Eight (62%) countries reported collecting such data.

Table 7. Presence of teacher training for HIV and life-skills education

Teacher Training	Anguilla	Antigua	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Jamaica	St. Kitts & Nevis	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
Teacher training curriculum includes SHN	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teachers given health education training	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Teachers given health education training pre-service	NA	✓	✓	NR	✓	NR	✓	✓	NR	✗	✗	✓	✓
Teachers given health education training in-service	NA	✓	✓	✓	✓	✓	✓	✓	NR	✓	✗	✓	✓
Teachers trained in life skills education	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teachers trained in life skills education pre-service	NA	✓	✗	NR	✓	NR	✗	✓	NR	✗	✗	✓	✗
Teachers trained in life skills education in-service	NA	✓	✗	NR	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teachers taught to protect themselves from HIV/AIDS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teachers taught to protect themselves from HIV/AIDS pre-service	✓	✓	✗	✓	✓	NR	✗	✓	✓	✗	✗	✓	✗
Teachers taught to protect themselves from HIV/AIDS in-service	NR	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teachers given HIV training	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teachers given HIV training pre-service	NR	✓	✗	✓	✓	NR	✗	✓	✓	✗	✗	✓	✗
Teachers given HIV training in-service	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teaching training materials for the primary level available	✓	✓	✓	✓	✓	NR	✓	✓	✓	✓	✓	✗	✓
Teaching training materials for the secondary level available	✓	✓	✓	✓	✓	NR	✓	✓	✓	✓	NR	✓	✓
Data collection on teachers trained and training materials in learning institutes	✗	✓	✗	✓	✓	✗	✓	✓	NR	✗	✓	✓	✓

✓= yes, ✗= no, NA= not applicable, NR= no response to the question

Figure 2. Number of countries offering pre-service or in-service training on life skills and HIV for teachers



3.4 School-based health and nutrition services

School-based health and nutrition services offer schools an effective way of improving the health and nutritional status of children, as well as a means to mitigate the impact of HIV. Health and nutrition services delivered through schools link resources in the health and education sectors in the existing infrastructure of the school with its skilled workforce (teachers and administrators), and can be cost-effective compared to some services provided by medical teams (World Bank & OUP, 2006). Especially in the Caribbean where school enrolments are high, these services when provided through schools allow for a higher coverage than through health systems.

Common services provided by countries to school-age children are: vaccinations and hearing and sight examinations in all 13 countries; school feeding in 12 (92%) countries; and dengue prevention in 11 (85%) countries (see Table 8). Vaccinations and hearing and sight examinations are administered by MoH staff in all countries providing these services. In Antigua, it is noted that the government also pays for spectacles for children. School feeding services in these countries are administered by teachers, with the exception of the Bahamas, where it is provided by MoH staff.

If parasitic worms are prevalent in an area, deworming programs for school-age children are recommended, the frequency of which depend on the level of worm prevalence. Teachers can be easily trained to distribute deworming tablets, which are very safe and simple to administer, and schools offer a cost-effective delivery mechanism to carry out such deworming programs, reaching large numbers of children though an already-established network.

Deworming programs for school-age children are taking place in eight (62%) countries, with six of these countries reporting that deworming is being delivered by MoH staff (information on Anguilla and Trinidad and Tobago is not available). In Guyana, teachers are not involved in deworming.

When micronutrient supplementation is carried out as a component of deworming programs, it can lead to a greater improvement in child health and education; for example iron supplementation reduces anaemia caused by worms. The Bahamas, Belize and St. Vincent and Grenadines (23%) carry out iron supplementation as a component of their deworming programs. Two (15%) countries, namely Belize and St. Vincent and Grenadines, reported administering Vitamin A supplements to school-age children. In Belize, vitamin A supplementation is given in conjunction with deworming by a Belizean initiative (funded by Vitamin Angels) and it is done specifically in the southern districts where worm prevalence and vitamin deficiency are known to be the highest.

As early pregnancy and sexually transmitted infections including HIV have been identified as issues of growing concern to school-age children in the Caribbean, the development and implementation of relevant and responsive reproductive health services in schools has been seen as important. The survey found that 11 (85%) countries are currently involved in providing reproductive health services to school-age children.

With counseling and access to free anti-retroviral therapy (ART) becoming more easily accessible, Ministries are encouraged to advocate for greater access and usage of these services by teachers. Twelve (92%) countries reported access to counseling services for teachers and other education employees.

Table 8. Health and nutrition services offered for school-age children and teachers

Health and Nutrition Services	Anguilla	Antigua	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Jamaica	St. Kitts & Nevis	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
Vaccinations for school-age children (SAC)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
School feeding provided for SAC	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vitamin A capsules provided for SAC	✗	✗	✗	✗	✓	NR	✗	✗	NR	✗	✗	✓	✗
Iron supplementation program for SAC	✗	✗	✓	✗	✓	NR	✓	✗	NR	✗	✗	✓	✗
Deworming programme for SAC	✓	✗	✓	✓	✓	✗	✗	✓	NR	✓	✗	✓	✓
Dengue prevention services for SAC	✓	✓	✓	✓	✓	✓	✓	✓	NR	✓	NR	✓	✓
Medical examinations for SAC	✓	✓	✓	✓	✓	✗	NR	✗	✓	✓	✓	✓	✓
Hearing and sight examinations for SAC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reproductive health services for SAC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗
Counselling services for teachers	✓	✓	✓	✓	✓	✓	✓	✓	NR	✓	✓	✓	✓

✓= yes, ✗= no, NR= no response to the question

3.5 Support to MoE SHN and HIV responses

There are a range of sources supporting education sector responses to SHN and HIV in the Caribbean region including national governments, development partners, civil society organizations and others. In six countries, namely the Bahamas, Barbados, Grenada, Guyana, Jamaica and Trinidad and Tobago, support is given to a Sector Wide Approach (SWAP) in education with one national sectoral plan including all education sub-sectors in a country. The SWAP brings together different partners such as donors and other stakeholders in the sector under a single government-led program.

Budgetary information gathered through the questionnaire is not deemed reliable and clarification on information relating to financial allocation by MoEs for their SHN and HIV responses is still required. Of the eight (62%) countries for which budget data has been provided, St. Kitts and Nevis reported the highest level of ministerial allocation for SHN with a 4.44% allocation from its budget (see Table 10). Of these eight countries, five reported the absence of an HIV allocation in the MoE budget. This information indicates that funding for HIV may be received from sources other than MoE. It also indicates that there may be a need for internal advocacy for HIV in the MoEs.

The Fast Track Initiative (FTI) is a global partnership to assist low-income countries to meet the education MDGs and the EFA goal that all children can access primary education by 2015. Guyana is the only country in the region currently eligible for funding from FTI. Funds from the FTI are used for SHN activities in Guyana, such as provision of water and sanitation in schools.

Non-governmental organizations and private companies that work in education, child health, or, more specifically, SHN and HIV prevention, can be an additional source of resources to education sector SHN and HIV responses. Seven (54%) MoEs reported contracting or partnering with non-governmental organizations (NGOs) to assist in the implementation of HIV prevention education (see Table 9). Separately, eight (62%) MoEs reported working with the private sector for support to HIV prevention education.

Table 9. Sources of support for MoE SHN and HIV responses

Support to MoE SHN and HIV/AIDS Responses	Anguilla	Antigua	The Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Jamaica	St. Kitts & Nevis	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
MoE implements a Sector Wide Approach (SWAP)	✗	✗	✓	✓	✗	✗	✓	✓	✓	✗	✗	✗	✓
Receive Fast Track Initiative (FTI) funding	✗	✗	✗	✗	✗	✗	✓	✓	NR	✗	✗	✗	NR
MoE contracts or partners with NGOs to support HIV education	✗	✗	✗	✓	✓	✗	✓	✓	✓	✗	✗	✓	✓
Private Sector working with MoE to support HIV education	✗	✓	✓	✓	✓	✗	✓	✗	✓	✓	✗	✓	✗

✓= yes, ✗= no, NR= no response to the question

Table 10. MoE budget allocated for SHN and HIV responses (in US$)

Support to MoE SHN and HIV Responses	Anguilla	Antigua	The Bahamas	Barbados	St. Kitts	St. Lucia	St. Vincent & Grenadines	Trinidad & Tobago
MoE budget for 2008	$ 8,149,301	$ 28,240,940	$ 236,893,665	$ 50,000,000	$ 16,518,854	$ 42,030,215	$ 30,850,806	$ 1,113,601,690
SHN budget as percentage of MoE budget	0.23%	0.00%	0.07%	0.01%	4.44%	0.10%	2.49%	NR
HIV budget as percentage of MoE budget	0.00%	0.00%	0.04%		0.00%	0.00%	0.00%	0.02%

Conclusions and Recommendations 4

CONCLUSIONS

The rapid survey and this resulting report contribute to the collection of locally relevant evidence, as well as regional information relevant to SHN and HIV, to build a sound evidence base at both country and regional levels to inform policy and strategy. It has further application as a resource for knowledge sharing as it provides a comparative perspective on activities and initiatives thus far implemented throughout the Caribbean region, and on the allocation and mobilization of resources used to support these activities and initiatives.

The overall picture derived from this exercise is a positive one. The rapid survey reports that the education sector response to SHN and HIV throughout the Caribbean region is well underway. A number of countries have responded to the HIV/AIDS epidemic with collaborative efforts between the Ministries of Health and Education, and have put in place sustainable activities to mitigate the impact of HIV on the education sector, while also addressing other health issues relevant to school-age children in the Caribbean context. The governments of the CARICOM countries are well placed to collaborate effectively to address challenges which persist – including stigma – through the education sector.

Survey responses indicate that the majority of the participating MoEs have in place a policy and management framework for SHN and HIV programming and a safe school environment. In many countries, the education sector is already involved in providing health education to staff and students, and a range of health and nutrition services. The extent of the SHN and HIV response varies between MoEs and is country-specific. Highlights of the response are as follows:

Health-related school policies

- Nine of the 13 MoEs have policies, strategies and work plans in place, demonstrating their commitment to SHN and HIV response.
- Ten of the 13 MoEs have a national policy on free and universal primary education to reduce financial barriers of education for orphans and vulnerable children.
- Ten out of 13 countries have an existing management framework in place for MoEs to manage and mainstream their response to SHN and HIV. Such a framework includes a SHN/HIV unit within the MoE, seen in seven countries; an inter-departmental coordination committee on SHN/HIV, in seven countries; and a HIV/AIDS coordinator at national and sub-national level, in 10 and three countries respectively. The national HIV/AIDS coordinator is financed by their MoE in six countries, and by the MoH in two countries.
- Twelve out of the 13 MoEs collect some data to facilitate ongoing monitoring and evaluation of their SHN programs. This data may include information on teacher training, school sanitation and teacher attrition.

Safe and supportive school environment

- All 13 countries have a mechanism in place to ensure that there is a safe and healthy environment in schools. This includes the presence of policies and practices to ensure that schools have safe water and sanitation, as found for eight and 10 countries respectively; are hygienic, reported by all countries; and promote the psychosocial well-being of teachers and students, as reported by 10 countries.
- Six of the 13 MoEs conduct annual sanitation surveys in all schools as a means of monitoring the implementation of safe school environment policies and improving and scaling up interventions.

Skills-based health education

- In all 13 countries, to varying degrees, the education sector is involved in providing skills-based health education including HIV prevention to staff and students. Schools generally utilize both a curricular and a peer-education approach in order to deliver important life skills education. Under the curricular approach, health and HIV prevention education is generally taught as part of health and family life education, which provides information on many different health concerns, such as hygiene, nutrition and disease prevention. Ten countries also deliver HIV prevention education in the non-formal setting.
- Twelve of the 13 countries have teachers are trained in life skills education. In all 13 countries teachers are trained to teach HIV prevention education. Teacher training on life skills and HIV is provided more often in-service than pre-service.

School-based health and nutrition services

- All 13 countries, to varying degrees, are involved in providing health and nutrition services to school-age children and teachers. Vaccinations and hearing and sight examinations take place in all 13 countries; school feeding takes place in 12 countries; iron and vitamin A supplementation take place in four and two countries respectively. Deworming for school-age children takes place in eight countries. Reproductive health services are provided to youth in 11 countries; while in 12 countries counseling is provided to teachers and other education employees.
- Vaccinations and hearing and sight examinations is provided by MoH employees in all countries providing these services.

- Where school feeding is provided, it is administered by teachers, except for the Bahamas where it is provided by MoH employees. Deworming in six of the eight countries is administered by MoH employees.

Support to MoE SHN and HIV responses

- Ten of the 13 MoEs receive external support for education sector responses to SHN and HIV. This support is derived from various sources including the private sector; NGOs and UN agencies. Seven MoEs contract or partner with NGOs to assist in the implementation of HIV prevention education. Separately, eight MoEs work with the private sector for support to HIV prevention education. Guyana is the only country eligible for EFA FTI funding; funds are used for SHN activities such as provision of water and sanitation in schools.

RECOMMENDATIONS

There are potential areas for enhancing or building on the data gathered from the rapid survey.

- First, the survey participants were unfamiliar with some aspects of the education sector response, such as the financial and budgetary information of programs and the financing of MoE HIV/AIDS coordinators, and responses were unclear in some cases. These data may be subsequently collected as part of a follow-up exercise, for discussions at future EduCan meetings, such as that planned during the 2009 CARICOM Council on Human and Social Development meeting.

- Second, data from this survey may be used to assess trends and evaluate progress of education sector responses to HIV. Most of the data collected in this survey relate to program activities and processes. Therefore, repeat surveys for monitoring progress may be conducted on an annual basis, using a methodology similar to this rapid survey for comparability.

- Last, additional qualitative and quantitative information on responses and the extent of activities taking place in- country will improve understanding of the quality, impact and scale of programs, and provide opportunities for sharing experiences and future planning.

There are also some recommendations for the SHN and HIV responses in the region that the members of the EduCan may consider:

A majority of MoEs have established effective policies and strategies for addressing SHN, HIV and other infectious diseases. At this stage, the focus might effectively shift from creating the policy environment to implementing the strategies. Further, since NCDs such as obesity and type 2 diabetes are emerging areas of concern in the region, greater policy emphasis on NCDs may prove beneficial.

School feeding is near universal in the 13 countries and territories, while micro-nutrient supplementation is, very focal. In addition, one-on-one interviews with coordinators suggest that there may be need for greater focus on the quality of food consumed by school-aged children. In the context of the region's growing epidemic of common NCDs there is opportunity to consider the coverage of micro-nutrient supplementation and to assess the quality of food provided through school feeding programs and accessed through food vendors in schools.

There is clear evidence that schools have placed strong emphasis on ensuring a hygienic and safe environment with psychosocial support for students in school. This survey did not address the availability of exercise facilities in schools but this may be an important factor for consideration given the emergence of common NCDs in Caribbean school-age children.

There is generally a high level of teacher training provided in the countries of the Caribbean. This typically includes training in life skills education and in relation to delivering HIV prevention messages. Teacher training, however, is primarily provided in-service and not as a substantive component in preparing teachers pre-service for teaching careers. This might indicate a need to focus on ensuring skilled teachers equipped with sexuality training.

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Annexes 6

6.1 Port-of-Spain Action Framework

Sector Policy Framework

Check Item	*Comments*
National HIV&AIDS Strategy • has been adopted by the government • includes education in a multi-sectoral approach	Demonstrates the government's commitment to responding to HIV&AIDS. The inclusion of the education sector shows the recognition of the role of the sector in the response. Addresses sector specific HIV&AIDS issues.
National Education Sector HIV&AIDS Strategy • has been adopted by the Ministry of Education • has been incorporated in the national sector plan	Shows how the sector plans contribute to the response to HIV&AIDS nationally. Inclusion in the education plan (and EFA) indicates how this strategy will be implemented.
Education Sector policy for HIV&AIDS • has been adopted by Ministry of Education • has been shared with all stakeholders, Greater Involvement of People with HIV&AIDS (GIPA), and disseminated • addresses gender, curriculum content, planning issues, and education needs of orphans and vulnerable children • includes workplace policy	The policy will only be effective if it is owned by the relevant stakeholders, especially the teaching unions, and if it is widely known and understood. Addressing curriculum at this stage can facilitate dialogue and agreement with the community on sensitive issues that can otherwise slow progress in implementation. Establishing policy is the essential first step in an effective response. Input from GIPA will ensure that the policy reflects the needs of people living with HIV&AIDS within the sector.
Workplace policy addresses • stigma and discrimination in recruitment and career advancement • sick leave and absenteeism • dissemination and enforcement of codes of practice, especially with respect to the role of teachers in protecting children • care, support and treatment of staff • access to voluntary counseling and testing (VCT)	HIV&AIDS presents major new issues in the workplace (the school, the office): recruitment and career progression are constrained by stigma and discrimination; sick leave policies rarely cope with long-term disease, and encourage undisclosed absenteeism; codes of practice that forbid sexual abuse of pupils are rarely enforced; easy access to VCT, treatment and psychosocial support. The Public Sector can often learn from the private sector in developing a workplace response.

Planning and Management Framework

Check Item	*Comments*
Management of the sector response requires: • **an interdepartmental committee** • **department focal points who have HIV&AIDS activities as a specific part of their job description** • **a secretariat or unit that supports the mainstreaming of the response, and has clear political support** • **understanding of new sources of financial support**	Mainstreaming the HIV&AIDS response requires, at least initially, mechanisms for involving all departments (the committee) and for implementation (the unit). Keys to success are: the focal points have space in their work program to allocate time to HIV&AIDS; the unit reports to the highest level; the unit is led at the department director level. The sector can now access financial resources (e.g., MAP, GFATM) often thought to be exclusive to the health sector.
For short to medium term planning, use the Education Management Information System (EMIS) or school survey data to assess: • **HIV&AIDS-specific indicators** • **teacher mortality and attrition data** • **teacher absenteeism data** • **district level data**	Even where an effective EMIS is unavailable, school survey data can be used to assess the impact of HIV&AIDS on the education system. This should relate district level education data to the geographical pattern of the epidemic, using epidemiological data from the health service.
For long term planning: • **Computer model projection of the impact of HIV&AIDS on education supply and demand** • **assessment of the implications of changes in supply for teacher recruitment and training** • **assessment of the implications of changes in the size of the school age population and the proportion of orphans and vulnerable children for education demand**	The effects of the epidemic have a time scale of decades and impacts, only slowly become apparent. Long term planning similarly requires projection of impact over decades, which is best achieved using computer projection models, such as EdSIDA, which combine epidemiological and education data. Projection allows for the planning of future teacher supply needs and, where necessary, the reform of teacher training schedules.

Prevention Framework

Check Item	*Comments*
Achieve Education for All	Completion of education is a social vaccine vs. HIV&AIDS.
Prevention curriculum requirements: • formal and non-formal, within the national curriculum • begin early, before the onset of sexual activity • use grade- and age- specific content • develop participatory teaching methods • include a life skills approach • use a carrier subject • teach in the context of school health (e.g., FRESH) • ensure community ownership and support	The aim is to develop knowledge and protective behaviours: start before risky behaviours have become established; match content to the development stage of the child; use teaching methods which establish skills, values and practices to help children protect themselves. Use of a single carrier subject (e.g., social studies) is often more realistic than more complex approaches (e.g., spiral, diffusion). Failure to involve the community in this potentially sensitive area is one of the major causes of delay in implementation.
Teacher training in HIV&AIDS prevention requires development of: • pre-service training and materials • in-service training and materials • messages and approaches that help teachers to protect themselves	Preventive education is more frequently taught as part of in-service training than pre-service. While it is necessary for both, new teachers may be more readily trained in the participatory methods that are required to teach the subject. Teacher training institutions frequently overlook the benefits of helping teachers to protect themselves.
Complementary approaches: • peer education • Ministry of Education has input to community IEC strategies • Ministry of Education coordinates with NGO prevention programs and GIPA to provide consistent messages • Ministry of Education assists Ministry of Health in promoting youth-friendly clinics for the treatment of sexually transmitted infections (STIs) and condom distribution	An holistic approach is essential for effective prevention. Peer education is particularly important for reinforcing active learning by youth. IEC strategies ensure consistent messages in the school, home and community. Building on existing NGO programs speeds up the response. Early and effective treatment of STIs is effective in reducing HIV transmission; youth need access to condoms to translate learned behaviours into practice.

Orphans and Vulnerable Children (OVC) Framework

Check Item	*Comments*
Barriers to education are removed: • **achieve Education for All** • **abolish school fees** • **develop a mitigation strategy to avoid informal and illegal levies** • **subsidize payment of informal levies**	Achieving EFA enhances access, including for OVC. School fees, in particular, may prevent OVC from accessing education. Abolition provides partial relief, but fees are often substituted by levies (e.g., for textbooks, PTA, uniforms). Social funds offering subsidies through schools, PTAs or the community can help overcome these barriers.
The Education System helps maintain attendance: • **offer conditional cash (or food) transfers** • **provide school health programs, including psychosocial counseling**	Ensuring that OVC are able to attend school is only the beginning: they also require support to remain in school. One effective method is to offer caregivers cash (or food) transfers that are conditional upon attendance. OVC have typically suffered severe shock, and benefit from school health programs based on the FRESH framework.
The Education Sector works with other agencies providing care, support and protection: • **MinEd coordinates with NGOs** • **MinEd coordinates with Ministry of Welfare/Social Affairs**	Long term care, support and protection of OVC are typically the mandate of social programs under Ministries of Welfare or Social Affairs. In practice, NGOs are often most directly involved in these programs and offer an immediate point of entry. In both cases, it is important that the Ministry of Education Department ensures that education system programs are complementary to these activities.

6.2 School Health, Nutrition and HIV/AIDS in the Caribbean Region Questionnaire

A. IDENTIFICATION:

1. Your Name:

2. Title/Affiliation:

3. Name of Country:

4. Highest administrative divisions of country: No. of Regions: *(specify the number)*

   These are known as: Provinces / Zones / Districts / other (please circle or specify)

5. Next highest administrative divisions of country: No. of Regions: *(specify the number)*

   These are known as: Provinces / Zones / Districts / other *(please circle or specify)*

B. POLICY PLANNING AND MANAGEMENT

Please indicate 'Yes' or 'No' for each of the following. In some cases you will be asked to fill in a blank with additional information.	**YES**	**NO**
1. Has your country been endorsed for funding through the FTI? (If yes, please provide policy document.)	☐	☐
2. Does the Ministry of Education (MoE) implement a Sector-Wide Approach (SWAP)? (If yes, please provide policy document.)	☐	☐
3. Does the MoE have an education sector policy? (If yes, please provide a copy.)	☐	☐
4. Does the MoE have an education sector strategy? (If yes, please provide a copy.)	☐	☐
5. Is there a national School Health & Nutrition (SHN) policy? (If yes, please provide a copy)	☐	☐
If yes, is it implemented by the Ministry of Health?		
If yes, is it implemented by the Ministry of Education?		
If yes, which schools are involved? (primary, secondary, and private, public)		
If yes, when was it implemented/accepted?		
6. Is there a SHN unit in the Ministry of Education?	☐	☐
If yes, is there a full time coordinator/manager of the unit?		
Is the unit free-standing?		
If not freestanding, is the unit a part of a directorate?		
If yes, which directorate?		
7. Does your SHN program involve a number of donors?	☐	☐
If yes, which ones? (Please attach a list)		

8. Are there SHN and/or HIV&AIDS coordinators/focal points at the sub-national level of the education delivery system?(Nomenclatures may vary from country to country) **(Yes/No, If Yes)**	SHN	HIV/ AIDS	SHN	HIV/ AIDS
Zonal?				
Provincial/Regional?				
District?				
Sub-District?				
Learning Facility?				

9. Is HIV&AIDS a part of the School Health and Nutrition unit in the Ministry of Education?	☐	☐
If no, is there an HIV&AIDS unit in the Ministry of Education?		

Please indicate 'Yes' or 'No' for each of the following. In some cases you will be asked to fill in a blank with additional information.	YES	NO
10. Is there an officially appointed HIV&AIDS coordinator/focal point in the Ministry of Education?	☐	☐
If yes, are the coordinators/focal points full time or part time?		
Does the coordinator /focal point have an official job description?	☐	☐
(If yes please provide a copy.)		
If yes, are they funded by external donor or MoE?		
11. Within the Ministry of Education, is there an SHN and/or HIV&AIDS interdepartmental committee?	☐	☐
If no, how is information shared between MoE staff involved in HIV?		
If yes, does the committee have clear Terms of Reference?		
(If yes, please provide a copy of TOR.)		
12. Do you have a National HIV&AIDS strategy?	☐	☐
(If yes, please bring a copy to the EduCan meeting in March.)		
13. Do you have an Education Sector HIV&AIDS strategy?	☐	☐
(If yes, please bring a copy to the EduCan meeting in March.)		
14. Do you have an Education sector HIV&AIDS action plan?	☐	☐
(If yes, please bring a copy to the EduCan meeting in March.)		
15. Is the Ministry contracting NGOs to assist in the implementation of its HIV&AIDS educational program?	☐	☐
16. In addition to NGOs, does the Ministry work with the private sector to assist in the implementation of HIV/AIDS education and outreach programs?	☐	☐
17. Is there a national work place policy? (If yes, please provide a copy.)	☐	☐
If yes, are HIV&AIDS issues addressed?		
If no, do you have an Education Sector HIV&AIDS policy that includes workplace regulations?		
(If yes, please provide a copy.)	☐	☐
18. Is there a national policy of free primary school Education For All (EFA)?	☐	☐
19. Has the Ministry of Education or any other authorized agency undertaken any impact projections/assessment of school health and nutrition initiatives on supply and demand in terms of attaining their EFA goals?	☐	☐
(If yes, please provide a copy of the report.)		
20. Does the MoE collect data at least annually on health-related attrition and absences of teachers?	☐	☐
If yes, at which levels are data collected?		
Zonal?		
Provincial/Regional?		
District?		
Sub-District?		
School?		
21. Does the MoE keep data on Orphans & Vulnerable Children (OVCs)?	☐	☐
If yes, at which levels are data collected?		
Zonal?		
Provincial/Regional?		
District?		
Sub-District?		
School?		
22. Do OVCs have to pay school tuition/fees?	☐	☐
What other fees do OVCs have to pay?		
23. Is there any program of conditional transfer of funds?	☐	☐
If yes, is it to:		
Relatives or Caregivers?		
Schools?		
24. Are there any affirmative action programs to boost the enrolment or attendance of school-age/school girls?	☐	☐

C. SCHOOL ENVIRONMENT

Please indicate 'Yes' or 'No' for each of the following. In some cases you will be asked to fill in a blank with additional information.	YES	NO
1. Is there a national policy that promotes a safe, child-friendly school environment?	☐	☐
2. Is there a national policy requiring that schools provide psychosocial support for students?	☐	☐
3. Is there a national policy requiring that schools provide safe, potable drinking water?	☐	☐
4. Is there a national policy requiring that schools provide hand washing facilities?	☐	☐
If yes, does this include provision of soap?	☐	☐
5. Is there a national policy requiring that schools provide separate latrines for boys and girls?	☐	☐
6. Is there a national policy requiring that schools provide separate latrines for students and teachers?	☐	☐
7. Is there an annual sanitation survey conducted in all schools?	☐	☐
8. Is there an established school hygiene and cleaning regimen that includes:	☐	☐
Scheduled rubbish removal?	☐	☐
Maintenance of school buildings and facilities in all schools?	☐	☐

D. HEALTH EDUCATION AND CURRICULUM

Please indicate 'Yes' or 'No' for each of the following. In some cases you will be asked to fill in a blank with additional information.	YES	NO
1. Is there a national health education curriculum?	☐	☐
If yes, can it be adapted to individual districts/regions/provinces?		
2. Is health education taught as a separate subject (i.e. not embedded in another subject)?	☐	☐
If yes, what is the name of the subject (i.e. health, life-skills..etc)?		
If no, what is the carrier subject?		
3. Is nutrition education taught in schools in any form?	☐	☐
If yes, is it taught in primary schools?		
If yes, is it taught in secondary schools?		
If yes, at what age is nutrition education introduced into schools?		
Is nutrition education offered in non-formal education?		
4. Is hygiene education taught in schools in any form?	☐	☐
If yes, is it taught in primary schools?		
If yes, is it taught in secondary schools?		
If yes, at what age is it introduced into schools?		
Is hygiene education offered in non-formal education?	☐	☐
5. Is dengue prevention education taught in schools in any form (i.e. knowledge based, life-skills, peer education, etc.)?	☐	☐
If yes, is it taught in primary schools?	☐	☐
If yes, is it taught in secondary schools?	☐	☐
If yes, at what age is dengue prevention education introduced into schools?	☐	☐
If yes, is dengue education taught in non-formal education and in out-of-school settings?		
6. Is there a program of peer education within the education sector?	☐	☐
(If yes, provide some manuals, guidelines, etc. that are used for this.)		
If yes, is it operational in primary schools?		
If yes, is it operational in secondary schools?		
7. Are there student-led youth groups which have the support of school administration officials to meet on school grounds to raise awareness of HIV/AIDS?	☐	☐
8. How many tertiary institutions (universities) exist in the country?	☐	☐
Of this number, how many have institutional HIV&AIDS policies?		
(Number) (Please provide copies)		

Please indicate 'Yes' or 'No' for each of the following. In some cases you will be asked to fill in a blank with additional information.	YES	NO
9. Are there training materials for tertiary (university) level HIV&AIDS education?	☐	☐
If yes, has there been an impact assessment?		
10. Do students in tertiary (university) level education have access to on-campus HIV/AIDS testing and counseling?	☐	☐
11. Is HIV&AIDS prevention education offered in schools in any form (i.e. knowledge based, life-skills, peer education, etc.)?	☐	☐
IF NO, LEAVE QUESTIONS 9-12 BLANK AND SKIP TO QUESTION 13.		
If yes, is it offered in primary schools?		
If yes, is it offered in secondary schools?		
If yes, at what age is HIV&AIDS prevention education introduced into schools?		
If yes, is HIV&AIDS prevention education taught in non-formal education and in out-of-school settings?		
12. If HIV&AIDS prevention education is taught in schools, is it embedded in another subject (a "carrier" subject)?	☐	☐
If yes, which subject/s?		
13. If HIV&AIDS prevention education is taught in schools, have you adopted a life-skills approach at the:	☐	☐
Primary level?		
Secondary level?		
Within non-formal education?		
14. If HIV&AIDS prevention education is taught in schools, is the HIV&AIDS educational program linked to other related topics such as reproductive health, substance abuse, domestic violence, etc? (If it is not taught in schools, leave blank.)	☐	☐
If yes, which topics?	☐	☐
The following questions refer to teachers and teacher training. Please indicate 'yes' or 'no' for each question.		
15. Does the teacher training curriculum include school health and nutrition?	☐	☐
16. Are teachers given health education training?	☐	☐
If yes, is this done during pre-service training?		
If yes, is this done during in-service training?		
17. Are teachers trained in the approach of delivering effective life-skills education to children?	☐	☐
If yes, is this done during pre-service training?		
If yes, is this done during in-service training?		
18. Are teachers given HIV&AIDS training?	☐	☐
If yes, is this done during pre-service training?		
If yes, is this done during in-service training?		
19. Are teachers taught to protect themselves from HIV?	☐	☐
If yes, is this done during pre-service training?		
If yes, is this done during in-service training?		
20. Do teachers have access to counseling concerning HIV&AIDS?	☐	☐
21. Are there training materials about HIV&AIDS for the:	☐	☐
Primary level?		
Secondary level?		
22. Are data collected on the number of teachers trained and the quantity of training material received by learning institutions?	☐	☐
If yes, at which levels are data kept:		
Zonal?		
Provincial/Regional?		
District?		
Sub-District?		
School?		

E. HEALTH AND NUTRITION SERVICES

Are these services provided for school-aged children? (Tick 'yes' or 'no' and, if yes, indicate the number of regions within which the service is offered.) Also indicate if the services are administered by teachers or Ministry of Health (MoH) staff* and whether indicators of service provision are collected and, if yes, where these are retained.	Administered by*: TEACHERS	Administered by*: MoH STAFF	NO. OF REGIONS	Are data collected annually indicating numbers of students receiving service?	Where are data held? (Zone/ Province /District etc.)
	YES ☐ NO ☐			YES ☐ NO ☐	
1. Vaccinations					
2. School feeding ☐ ☐				☐ ☐	
3. Hearing and sight examinations ☐ ☐				☐ ☐	
4. General medical examinations ☐ ☐				☐ ☐	
5. Deworming program (i.e. providing deworming tablets) ☐ ☐				☐ ☐	
6. Reproductive health (i.e. pregnancy, STIs) ☐ ☐				☐ ☐	
7. Dengue prevention ☐ ☐				☐ ☐	
8. Iron supplementation program (i.e. providing iron tablets) ☐ ☐				☐ ☐	
9. Micronutrient (providing Vitamin A capsules) ☐ ☐				☐ ☐	

* Note that if teachers conduct the examinations (with or without supervision by MoH staff) then tick the 'Administered by Teachers' column. The aim is to identify which programs are teacher led, even though it is often normal practice for MoH staff to be nominally responsible for the activity and of course for the referrals to MoH facilities.

F. FINANCES

Give amounts in local currency only: $1 = **date**

	THIS YEAR	LAST YEAR
1. What is the Ministry of Education budget? (local currency)		
2. What is the budget of the MoE allocated to School Health and Nutrition?		
3. What is the budget of the MoE allocated to HIV&AIDS?		
4. What is the proportion of national versus external financing of SHN and HIV&AIDS activities? (in percent)		

G. SUPPLEMENTAL QUESTIONS

1. Who finances the HIV&AIDS Coordinator (e.g. the MoE, the MoH, NAC, etc.)? Please explain.

2. What percentage of school aged children are currently taking an HIV&AIDS course?

3. Who are the external donors who support the Education Sector with financial resources?

4. Name any practices/activities that you have heard of in the Caribbean region that you would like to learn more about as an example of "good practice." This is not asking for examples solely from your country; the idea is to find out what practices/activities may be highlighted throughout the region as good practice in order to contribute to information sharing.

H. Does your ministry participate in regional or sub-regional activities regarding SHN and/or HIV&AIDS? Please attach a list naming the institutions and the activities.

I. Below, please elaborate further about anything that is not covered in the questions above. Add additional pages if needed.

6.3 Education Sector HIV/AIDS Coordinator Network (EduCan) List of HIV Focal Points

	Name	Institution	Country/Territory	Email
1	Maureen Lewis	Ministry of Education Sports and Youth	Antigua and Barbuda	lenorelew@hotmail.com
2	Glenda Rolle	Ministry of Education, Youth, Sports and Culture	The Bahamas	grolle54@yahoo.com
3	Hughson Iniss	Ministry of Education, Youth Affairs and Sports	Barbados	hinniss@mes.gov.bb
4	Patricia Warner	Ministry of Education and Human Resource Development	Barbados	
5	Carolyn Codd	Ministry of Education	Belize	hflebelize@gmail.com
6	Thomas Holmes	Ministry of Education	Dominica	hthomas54@hotmail.com
7	Patrick Thompson	National AIDS Directorate	Grenada	nad@spiceisle.com
8	Arthur Pierre	Ministry of Education & Human Resource Development	Grenada	pynters@yahoo.com
9	Sharlene Johnson	Ministry of Education	Guyana	svj95@yahoo.com
10	Christopher Graham	Ministry of Education and Youth	Jamaica	edhivaids@yahoo.com
11	Patricia Beard		Joint British and Dutch overseas Territories (Anguilla)	aidsresearch@anguillanet.com
12	Sandra Fahie	Department of Education	Joint British and Dutch overseas Territories (Anguilla)	fahiesandra@yahoo.com
13	Ruby Thomas	Ministry of Education	St. Kitts and Nevis	ruthalithom@gmail.com
14	Sophia Edwards-Gabriel	Ministry of Education	St. Lucia	sofie_edwards@yahoo.com
15	Abner Richards	Ministry of Education	St. Vincent and the Grenadines	messiahyahweh@yahoo.com
16	Muriel Gilds-Muller		Suriname	rofa@cq-link.sr
17	Patricia Downer	Ministry of Education	Trinidad and Tobago	pat_downer46@yahoo.com

Caribbean Education Sector HIV and AIDS Coordinator Network (EduCan)
EDC Caribbean Office,
c/o UNICEF, United Nations House
Marine Gardens, Hastings
Christ Church, Barbados
www.educan.org

Education Development Center Inc. (EDC)
55 Chapel Street
Newton, MA 02458-1060, USA
www.edc.org

The Partnership for Child Development
Department of Infectious Disease Epidemiology
Imperial College Faculty of Medicine
St. Mary's Campus, Norfolk Place
London W 1PG, UK
www.schoolsandhealth.org
www.child-development.org

The World Bank
1818 H Street, NW
Washington, DC 20433, USA
www.worldbank.org

UNESCO Kingston Cluster Office for the Caribbean
3rd Floor, The Towers
25 Dominica Drive,
Kingston 5 Jamaica
www.unesco.org/kingston

EDUCAN CARIBBEAN EDUCATION SECTOR HIV AND AIDS COORDINATOR NETWORK

EDC

PCD The Partnership for Child Development

UNESCO United Nations Educational, Scientific and Cultural Organization Kingston Office